DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED OMB NO. 0938-0193

FILE

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 97-015 | STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

2: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10-1-97

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.300-321

7. FEDERAL BUDGET IMPACT: *
a. FFY 98 $ 500
b. FFY 99 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Outpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 31, 1997

16. RETURN TO:
Bridget Landers
Coordinator for State Plan, DMA
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 31, 1997

18. DATE APPROVED:
June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1997

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald Preston

22. TITLE:
Associate Regional Administrator for Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

* projected marginal impact expressed in thousands

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Non-Institutional Reimbursement

Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

I: OVERVIEW

On August 6, 1996, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the MassHealth program's sixth Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as MassHealth providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth recipients with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/ surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than 50% of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA. All eligible acute hospitals are participating providers.

The RFA was amended effective October 1, 1997 to incorporate the following updates and adjustments:

- A rate update of 2.14% was applied to outpatient clinic, ED visit rates, significant procedure rates, outpatient observation, and recovery room rates;
- The wage area adjustment was updated to reflect the most recent HCFA wage index information (1994);
- Payment for significant procedures performed on an outpatient basis will be made according to Ambulatory Patient Group (APG) methodology;
- Covered services provided through Off-Site Radiation and Oncology Treatment Centers will be reimbursed according to the lower of the Medicare fee schedule or the hospital's usual and customary charge.

II: DEFINITIONS

Ambulatory Patient Group (APG) - A group of outpatient services that have been bundled for purposes of categorizing and measuring casemix and setting rates. It is based on the 3M Corporation's APG version 2.0.

Clinic Visit - A face-to-face encounter, provided on an ambulatory basis, between an eligible recipient and a licensed practitioner (such as a physician, optician, optometrist, or dentist) or other medical professional under the direction of a licensed practitioner in a hospital OPD or a hospital-licensed health center for diagnosis, examination, or treatment.

Clinical Laboratory Service - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Community-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

Contract (Hospital Contract or Agreement) - The agreement executed between each selected hospital and the Division.

Contractor - Each hospital that is selected by the Division after submitting a satisfactory application in response to this RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

Division - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

Division of Health Care Finance and Policy (DHCFP) - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services created pursuant to G.L. c.118G. DHCHP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

Emergency Department (E.D.) - A hospital's Emergency Room or Level I Trauma Center which is located at the same site as the hospital's inpatient department.

Emergent Care - Emergent care shall mean medical care required immediately due to illness or injury with symptoms of sufficient severity that a prudent lay person would believe there is an immediate threat to life or high risk of permanent damage to the individual's health. Emergent conditions are those which require immediate treatment at the most accessible hospital Emergency Department. Emergent care does not include urgent care and primary care.

Health Maintenance Organization (HMO) - An entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance to operate under M.G.L. c. 176G, or that otherwise meets the State Plan definition of an HMO.

Hospital - Any hospital licensed under M.G.L. c. 111, §51 (and the teaching hospital of the University of Massachusetts Medical School), and which meets the eligibility criteria set forth in Section 1 of Attachment 4.19B (1) of this State Plan.

Hospital-Based Entity - Any entity which contracts with a hospital to provide medical services to recipients, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital-licensed health center.

Hospital-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide services to recipients, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital licensed health center. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

Hospital-Licensed Health Center (HLHC) - A facility which is not physically attached to the hospital that (1) operates under the hospital's license; (2) meets the Division's requirements for reimbursement as a HLHC as provided at 130 CMR 410.413; (3) is approved by and enrolled with the Division's Provider Enrollment Unit as a HLHC; (4) possesses a distinct HLHC provider number issued by the Division; (5) is subject to the fiscal, administrative, and clinical management of the hospital; and (6) provides services to recipients solely on an outpatient basis.

Hospital Outpatient Department - A department or unit located at the same site as the hospital's inpatient facility that operates under the hospital's license and provides services to recipients on an ambulatory basis. Hospital outpatient departments include day surgery units, primary care clinics, and specialty clinics and do not include E.D.s.

Level I Trauma Center - A hospital with a current Level I Certification of Verification from the American College of Surgeons (ACS).

Managed Care Organization (MCO) - The Managed Care Organization with whom the Division contracts to administer the Division's Mental Health and Substance Abuse Program (MH/SAP)

Medicaid (also referred to as MassHealth) - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act, and the Waiver.

Observation Services - Outpatient services consisting of the use of a bed and intermittent monitoring by professional licensed staff which is reasonable and necessary to evaluate an outpatient's condition in order to determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided under the order of a physician. Observation services usually do not, but may, exceed twenty-four hours.

Off-Site Radiation and Oncology Treatment Center - A hospital-owned or independently owned facility, not located at the site of the hospital's inpatient facility or hospital-licensed health center, that (1) provides radiation and oncology treatment; (2) is approved by and enrolled with the Division's Provider Enrollment Unit as an Off-Site Radiation and Oncology Treatment Center; (3) possesses a distinct provider number issued by the Division; (4) provides services to recipients solely on an outpatient basis; and (5) possesses appropriate DPH licensing for the provision of Radiation and Oncology Treatment.

Outpatient Services - Services reimbursable by the Division pursuant to the RFA which are provided to recipients on an ambulatory basis when rendered on-site at a hospital outpatient department or at a hospital-licensed health center.

Pediatric Specialty Clinic - An outpatient specialty clinic (as approved by the Division) at a pediatric specialty hospital or at a hospital with pediatric specialty (inpatient) units, which provides specialty care to Medicaid recipients.

Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

Primary Care - Primary care shall mean medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention and referral when necessary. Primary care does not require the specialized resources of a hospital Emergency Department.

Primary Care Clinician Program (PCCP) - A comprehensive managed care program with primary care clinicians managing enrolled recipients' medical care.

Rate Year (RY) - The period beginning October 1 and ending September 30. RY98 begins on October 1, 1997 and ends on September 30, 1998.

Recipient (also referred to as member) - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

Significant Procedure Groups - A subset of Ambulatory Patient Groups consisting of most, but not all surgical procedures, other significant procedures, and other outpatient services that occur the day before, the day of, and the day after a significant procedure.

Site-of-Service List - Those services (including visits, treatments and procedures) that do not need to be provided in an outpatient department.

Trauma Team - A group of healthcare professionals organized to provide care in a Level 1 Trauma Center which satisfies the guidelines of "Qualifications of Trauma Care Personnel", as specified in the American College of Surgeons Committee on Trauma's "Resources for Optimal Care of the Injured Patient: 1993".

Upper Limit - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.

Urgent Care - Medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care is appropriately provided in a clinic, physician's office or in a hospital Emergency Department if a clinic or physician's office is inaccessible. Urgent care does not include emergent care and primary care.

Usual and Customary Charges - Routine fees that hospitals charge for outpatient services rendered to patients regardless of payer source.

Waiver - the Section 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996.

III: NON-COVERED SERVICES

The Division will reimburse Medicaid participating hospitals at the rates established in the RFA for all outpatient and emergency department services provided to Medicaid recipients except for the following:

A. Mental Health and Substance Abuse Services for Recipients Assigned to the MH/SAP

The MCO contracts with a provider network to deliver mental health and substance abuse services for Medicaid recipients assigned to the MH/SAP. Hospitals in the MCO's network are paid by the MCO for services to recipients assigned to the MH/SAP, pursuant to the contract between the MCO and the hospital.

Hospitals that are not in the network (hereinafter "Non-Network Hospitals") do not qualify for Medicaid reimbursement for recipients assigned to the MH/SAP seeking mental health or substance abuse non-Emergent Care, except in accordance with a service specific agreement with the MCO. Non-Network Hospitals that provide medically necessary mental health and substance abuse Emergent Care to MH/SAP assigned recipients qualify for reimbursement by the MCO.

Hospitals are not entitled to any reimbursement from the Division, and may not claim such reimbursement for any services which are reimbursed by the MCO.

B. HMO Services

Hospitals providing services to Medicaid recipients enrolled in HMOs will be reimbursed by HMOs for those services.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to Medicaid recipients enrolled in an HMO where such services are covered by the HMO's contract with the Division. Furthermore, hospitals may not "balance bill" the Division for any services covered by the HMO's contract with the Division. HMO reimbursements shall be considered payment in full for any HMO-covered services provided to Medicaid recipients enrolled in an HMO.

C. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

D. **Hospital Services Reimbursed through Other Contracts or Regulations**

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made pursuant to the contract and/or regulations governing the special program initiative, and not through this RFA and resulting contract.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Non-Institutional Reimbursement

IV: REIMBURSEMENT SYSTEM

A. Outpatient Services (Rates in Appendix D)

Rates for outpatient services covered under a contract between the acute hospital and the MH/SAP MCO that are provided to Medicaid patients eligible for or assigned to the Division's MH/SAP MCO shall be governed by terms agreed upon between the acute hospital and the MH/SAP MCO.

Hospitals will not be reimbursed on an outpatient basis when an inpatient admission to the same hospital, on the same date of service, occurs following provision of outpatient services. Reimbursement for such outpatient services will be provided through the acute hospital inpatient payment system only. See State Plan Attachment 4.19A.

The following methodology will apply to outpatient services when those services are rendered at hospital outpatient departments and at hospital-licensed health centers. To be reimbursed for any services provided at a site other than the hospital outpatient department, the hospital must enroll that site with the Division as an appropriate provider type. If the site is not recognized by Division as a provider type, no service provided to a recipient at that site is reimbursable.

The Division is phasing in a new payment methodology for outpatient services based on the 3M Corporation's Ambulatory Patient Groups (APG), version 2.0. Outpatient Significant Procedures performed on or after October 1, 1997, as well as all outpatient and emergency department services provided on the day before, the day of, and the day after a Significant Procedure will be reimbursed according to APG Significant Procedure Groups.

The applicability of outpatient payments described in sections IV.A.2-7 are as follows:

i. All outpatient services provided before September 30, 1997 shall be reimbursed as set forth in sections IV.A.2-7.

ii. All outpatient services which are not provided the day before, the day of, or the day after a significant procedure as described in section IV.A.9, shall be reimbursed as set forth in sections IV.A.2-7.

iii. All outpatient services provided the day before, the day of, or the day after a significant procedure performed on or after October 1, 1997 shall be bundled into the reimbursement provided for a Significant Procedure APG in accordance with section IV.A.9, and not in accordance with sections IV.A.2 - 7.

iv. Physician services will not be bundled as part of APG Significant Procedure Groups.

v. All conditions and limitations on outpatient services apply regardless of the method of reimbursement.

1. Physician Payments

Physician payments are excluded from the APG methodology.

a. A hospital may only receive reimbursement for physician services provided by hospital-based physicians to Medicaid recipients. The hospital must claim payment in accordance with, and subject to the Physician Regulations at 130 CMR 433.000 et seq., and the payment rules as set forth in section IV. Except as otherwise provided in Section IV.A.1.b below, such reimbursement shall be the lower of i) the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00, 17.00 and 18.00; ii) the hospital's usual and customary charge for physician fees; or; iii) the hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than hospital-based physicians.

Physician fee schedules are available at the State House Bookstore.

b. For physician services provided by a hospital-based physician for an outpatient service included on the site-of-service list, the hospital will be reimbursed 79% of the fee established in the DHCFP Regulations at 114.CMR 16.00, 17.00 and 18.00, or at 100% of the hospital's usual and customary charge for physician fees, or 100% of the hospital's actual charge submitted, whichever is lower.

c. Hospitals will be reimbursed for physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the Clinic Visit Payment and, as such, are not reimbursable separately.

d. Hospitals will not receive a physician payment for outpatient services provided by a community-based physician.

2. Clinic Services

a. Clinic Visit Payment

i. Each hospital's cost-to-charge ratio was calculated from expenses and revenues using the FY90 RSC-403 cost report for each hospital for which adequate data were available. The cost center identified as the supervision component of physician compensation was included.

Additionally, capital from the FY90 MAC report, excluding major moveable equipment depreciation which is already in the RSC-403 report, was added to the allowed cost per visit. The hospital's Medicaid costs were then calculated by applying the cost-to-charge ratio to the hospital's Medicaid charges, from the Medicaid claims data base. Medicaid average cost and charge per visit were then calculated, and the lesser of cost per visit or charge per visit was taken as the hospital's allowable Medicaid cost per visit.

The wage component of each hospital's allowable Medicaid cost per visit was then adjusted by the Medicare wage area index used in the RY94 RFA to remove the effect of wage differences. Finally, an efficiency standard was calculated by ranking hospitals from lowest to highest with respect to adjusted allowable Medicaid costs per visit; producing a cumulative frequency of visits for these hospitals; and establishing the weighted median adjusted allowable cost per visit as the adjusted maximum cost per visit for each hospital. The standard was established as the weighted seventy-fifth percentile of the allowable Medicaid cost per visit.

ii. The statewide weighted mean cost per visit was then calculated by weighting each hospital's adjusted maximum Medicaid cost per visit by the ratio of the hospital's visits to statewide visits. The resulting weighted mean cost per visit became the base rate for a clinic visit, less the professional component, at all hospitals. The labor component of the base rate was then adjusted by the FY93 Medicare wage area index to derive each hospital's rate. Finally, this Medicaid rate was multiplied first by an inflation factor of 3.35% to reflect price changes between RY92 and RY93, by an inflation factor of 3.01% to reflect price changes between RY93 and RY94, by an inflation factor of 2.80% to reflect price changes between RY94 and RY95, by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, by an inflation factor of 2.38% to reflect price changes between RY96 and RY97, and by an inflation factor of 2.14% to reflect price changes between RY97 and RY98. For RY98, the wage area index will be updated with audited wage data from the FY94 Medicare Cost Report (2552).

iii. Hospitals in the same Medicare designated wage area will receive the same per visit payment.

b. Hospitals will not be reimbursed for the clinic visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following the clinic visit.

c. **Site-of-Service Limitation on Clinic Visit Payments**

Except as provided in the following paragraph, hospitals will not receive a clinic visit payment for an outpatient service when the accompanying physician service is included on the site-of-service list. The Division will reimburse the hospital for medically necessary laboratory and radiology services associated with such services, and for those ancillary services whose costs are not included in the physician payment.

Hospitals will receive a clinic visit payment for an outpatient service included on the site-of-service list only if the service is provided at the same site as the hospital's inpatient facility or hospital-licensed health center, by (i) a hospital-based physician or (ii) an outpatient department or a hospital-based entity which is enrolled with the Division as a PCC when providing services to its enrollees.

d. Physician Payment

In addition to the clinic visit payment, when a hospital-based physician provides services during a clinic visit, the hospital may be reimbursed for such physician services in accordance with section IV.A.1 above.

3. <u>Radiology Services</u>

Except as otherwise provided in Section IV.A.10, hospitals will be reimbursed for radiology services as follows:

a. Radiology Fee Schedule

For RY98, hospitals will be reimbursed for radiology services according to the principles of the 1997 Medicare fee schedule, as identified and amended by the Division, or the hospital's usual and customary charge, whichever is lower.

b. Physician Payment

Notwithstanding any provision to the contrary, in addition to the above radiology service fee, when a hospital-based physician provides services during a radiology service, the hospital may, when the service is not reimbursed with a global fee that covers both technical and professional portions, be reimbursed for such physician services in accordance with Section IV.A.1.

4. Laboratory Services

For RY98, hospitals will be reimbursed for laboratory services according to the principles of the 1997 Medicare fee schedule, as identified and amended by the Division, or the hospital's usual and customary charge, whichever is lower. The Medicare fee will be payment in full for any laboratory service rendered by the hospital.

5. Ancillary Services

Except as provided in Section IV.B.3, hospitals will be reimbursed for outpatient ancillary services according to a cost-to-charge ratio or the hospital's usual and customary charges, whichever is lower.

The cost-to-charge ratio for ancillary costs was derived by taking total ancillary costs including capital from the FY93 RSC-403 (Schedule II, Line 78, Column 5) and dividing by the total ancillary revenues from the FY93 RSC-403 (Schedule II, Line 78, Column 8) to arrive at the hospital-specific aggregate ancillary cost-to-charge ratio.

Hospitals may not bill for hospital-based physician services to accompany charges for ancillary services.

This cost-to-charge ratio will be applied to usual and customary charges for ancillary services. Such services include, but are not limited to, the following revenue centers:

Pharmacy (25X)
IV Therapy (26X)
Medical/Surgical Supplies and Devices (27X)
Oncology (28X)
Durable Medical Equipment (29X)
Respiratory Therapy (41X)
Pulmonary Function (46X)
Audiology (47X)
Cardiology (48X)
Osteopathic Services(53X)
Radiology Supplies (62X)
Cast Room (70X)
Labor Room/Delivery (72X)
EKG (71X)

EEG (74X)
Gastrointestinal Services (75X)
Treatment Room (76X)
Lithotripsy (79X)
Psychiatric Treatment (90X)
Other Diagnostic Services (92X)
Other Therapeutic Services (94X)

6. Therapy Services

The Division will reimburse acute outpatient hospitals for physical, occupational, or speech/language therapy services according both the Therapist Regulations in 130 CMR 432.000 and the hospital's cost-to-charge ratio or the hospital's usual and customary charges, whichever is lower.

The cost-to-charge ratio for all therapy costs was derived by taking total ancillary costs including capital from the FY93 RSC-403 (Schedule II, Line 78, Column 5) and dividing by the total ancillary revenues from the FY93 RSC-403 (Schedule II, Line 78, Column 8) to arrive at the hospital-specific aggregate ancillary cost-to-charge ratio.

7. Recovery Room Services and Observation Services

a. Fee Schedule

Hospitals will be reimbursed for recovery room and observation services as follows.

Each hospital's RY97 SPAD was multiplied by the number of its non-psychiatric Medicaid discharges for the period June 1, 1995 through May 31, 1996. This product was divided by the total number of non-psychiatric Medicaid discharges in the state for the same period. This average SPAD was then divided by the weighted average length of stay for all hospitals with the number of discharges for the period June 1, 1995 through May 31, 1996 used as each hospital's weight. The result was multiplied by 0.5079 to remove ancillaries, divided by 24 to get an hourly rate, and updated by an inflation factor of 2.14%.

The hourly rates were collapsed into three categories: 0 to 6 hours; 6 to 12 hours; and 12 to 24 hours. Each rate corresponds to the midpoint of the range; for example, the rate for 0 to 6 hours is 3 times the hourly rate.

If a hospital provides observation services for more than 24 consecutive hours, the hospital should treat the 25th hour as the beginning of a new time period.